tissues of the abdominal wall and consequent breaking down of the scar at a subsequent period, than of influencing the existing peritoneal tuberculosis.

When the fluid is purulent (cold abscess) it is better to insert a drainage-tube within the lips of the wound, and to remove it on the second or third day, when the amount of discharge is no longer sufficient to soak the dressings. To leave in a drainage-tube longer is injurious, as on the one hand it favors the formation of a sinus, and on the other its inner end may, by its mechanical pressure on the weakened walls of the intestine beneath, favor perforation of the latter and formation of a fecal fistula.

In cases of encysted or circumscribed fluid the consensus of opinion points to operative interference as especially indicated in this group, and experience has shown that it is in the majority of cases remarkably successful.

The author concludes from five personal cases and the experience of others that the adhesive type of tubercular peritonitis, while less favorable than the cases in which fluid accumulation is the chief feature, are capable of being favorably influenced by laparotomy, provided there is no serious tubercular lesion elsewhere in the body.

### HYPERTROPHY OF THE PROSTATE WITH COMPLETE AND CHRONIC RETENTION. DOUBLE CASTRATION. CURE.

ALBARRAN (*Annal. des mal. des organs genito-urin.*, August, 1895) reports the following case: Patient, sixty-nine years of age, having good family history, had had four attacks of gonorrhœa. For the past four years he had urinated more frequently than formerly, getting up once or twice in the night. Since the accentuation of this difficulty the patient has been compelled to strain for a considerable time before the urine began to flow. In June of 1894 he had his first retention of urine, which lasted for twenty-four hours. Since that time the number of micturitions had been increased, thirteen times a day, four or five times a night, while the urine has become turbid. In the latter part of December two hypogastric punctures were necessary to relieve him of retention, and subsequently he has been obliged to use the catheter regularly, occasionally passing a small quantity. Catheterism became difficult at the beginning of June.

Condition at the time of operation: The urethra is not markedly indurated or irregular in the penile portion, but the prostatic portion is elongated. The bladder is insensible, though extending to the umbilicus. Rectal palpation showed a moderately hypertrophied prostate, smooth, without irregularities, sluggish to the touch. A soft catheter could not be passed into the bladder. The urine was turbid, contained a slight amount of pus, but no casts. The general condition of the patient was medium, but he had no fever and very little appetite. Regular catheterization with lavage produced very little marked improvement in ten days' time.

The afternoon of the day of the operation the patient passed spontaneously 20 grammes of urine. The next day 200 grammes, then 400, 600, until on the seventh day he passed 1500 grammes. The amount of residual urine after spontaneous urination was on the eighth day 300 grammes, on the eleventh day 180 grammes. From the thirteenth to the twenty-first day it was between 135 and 150 grammes. On the twenty-fourth day it fell to 25 grammes. Since then it has remained between 16 and 20 grammes.

The patient left the hospital on July 20th. He urinated five or six times a day, and once in the night. The residual urine was only 15 grammes. The prostate had diminished about one-fifth of its volume. A soft catheter could be easily passed.

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### LIGATURE OF THE INNOMINATE ARTERY.

BURRELL (*Boston Med. and Surg. Journ.*, August 8, 1895) reported a rare case of ligation of the innominate artery in which the patient lived 104 days after operation. He had been up and about for a number of weeks attending to his affairs, and died of hypertrophy and dilatation of the heart and general arterial sclerosis. The innominate artery was closed and the aneurism had shrunk. The patient might have lived for a long time, so far as the ligation of the innominate was concerned.

The author believes that this case teaches :

1. That a patient with general arterio-sclerosis and an enlarged and dilated heart may be kept under ether an hour and a half, subjected to a severe operation, and recover with little shock.

2. That while the ligation of the innominate artery is not of necessity fatal, yet it will always be an extraordinary operation, fraught with danger from the cutting off of an extensive area of circulation. The removal of the sterno-clavicular articulation, and such a portion of the sternum as may be necessary, makes the performance of the operation more practical and one of relative simplicity and safety.

3. That the absence of pain or marked discomfort following the operation, the complete relief of all the patient's symptoms, and his almost uneventful recovery are remarkable.

4. That the secondary hemorrhages which have occurred in almost all of the recorded cases were undoubtedly due to local sepsis, and that the recovery of this case was due to the accuracy with which it was possible to place the ligatures and to the asepsis.

5. That if the innominate is ligated at all, two ligatures are necessary, one to act as a breakwater by obstructing the constantly recurring waves of blood coming from the aorta.

6. That the collateral circulation was principally established in this case by a downward stream of blood from the right carotid and vertebral arteries into the subclavian artery. That while the fusiform aneurism had shrunken there was very little clot above the second ligature. This would lead him in another case of fusiform aneurism in this situation to ligature the carotid, if possible the subclavian in its first part, and, if practical, the vertebral.

7. That the unique behavior of the first ligature that was applied to the innominate is perhaps the most interesting fact which we learn from this case. When the innominate artery was tied something in the wall was felt to give way. The ligature gradually cut its way through the coats of the vessel, followed by an inflammation in the organization which prevented a secondary hemorrhage, and finally rested, organized, and probably covered with a smooth layer of intima inside the innominate artery. This places a new factor at our disposal as regard final disposition of the ligature.